STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O. Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

COMPLAINT

Please print or type

SUBJECT INFORMATION *(Registered Nurse (RN), Applicant Or Unlicensed Person Claiming To Be An RN – Complete All Known Information.)*
Name *(Last, First, Middle):* **RN Number:**
Home Address *(Number & Street):*
City: **State:** **Zip Code:**
Employer:
Business Address *(Number & Street):*
City: **State:** **Zip Code:**
Home Phone: **Business Phone:**
Additional Information *(Birthdate, Former Name, etc.):*

PERSON REGISTERING COMPLAINT
Name *(Last, First, Middle):*
Address *(Number & Street):*
City: **State:** **Zip Code:**
Home Phone: **Business Phone:**
Relationship to Nurse *(*Patient, Coworker, Friend, etc.):*

****If you are the patient or a patient's legal representative, please complete the attached Release Form***

DETAILS OF COMPLAINT **(***Who, What, Where, When, Why, How; Include Copy of Relevant Documents; List Any Witnesses & Telephone Numbers. Use "Tab" to continue on next page if additional room is necessary.)*

Your Signature **Date**

DETAILS OF COMPLAINT _ (*Continued)*

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RELEASE OF CONFIDENTIAL INFORMATION

If you are filing a complaint and you were the patient or if you are a patient's legal representative, the Board of Registered Nursing (BRN) requests that you complete this "Release of Information " form in order to assist us in the investigation of your complaint. For the purpose of investigation and adjudication of your complaint to the BRN.

I, _____, hereby authorize
(Complainant/Client/Patient – include date of birth*)

_____
(Person or entity and telephone number from which information may be obtained)

to disclose all records and information and answer any questions pertaining to the diagnosis and course of my (or patient's) treatment to the Board of Registered Nursing ("Board"), any Board representatives, related local, state and federal governmental agencies, including but not limited to, investigators and legal staff. I further agree to allow the Board, Board representatives and related governmental agencies, to process and possibly file other charges based on my complaint against:

_____
(If known, include name and/or license number of subject(s))

I understand that this information will be maintained in confidence, and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of California laws and regulations. I also understand that the subject of my complaint (the Registered Nurse I am complaining about) may receive a copy of my records pursuant to the Administrative Procedures Act.

This authorization shall be valid until completion of an investigation and prosecution, including any investigation and preceding by another governmental agency that has requested your records and information.

_____ _____
Client Signature Date

OR:

_____ _____
Client's Representative/Relationship Date

(Attach written proof of authorization to act on client's behalf. You have a right to receive a copy of this authorization.)

*Date of birth is needed to positively establish the identity of the complainant/client